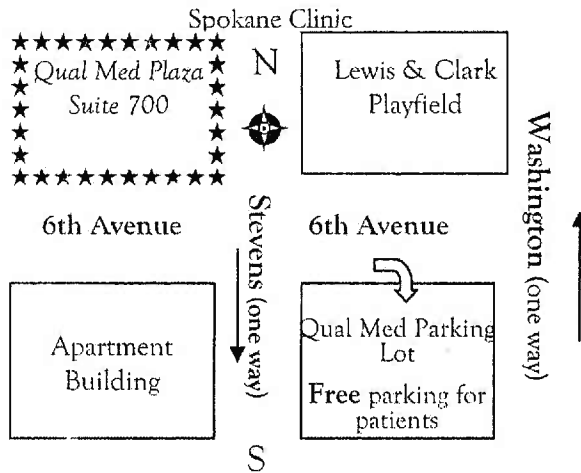


Directions



Travel south on Stevens, turn left on Sixth Avenue. Parking in the Qual Med Parking Lot (**free for patients**). We are located "kitty corner" in the Qual Med Plaza Suite 700. **Handicap Parking is available in front of our building.**



From top left: Cinda Reed, ARNP, Ron England, MD, Kerry Drain, MD, Bottom Left: Michael Kraemer MD & Steven Kernerman DO

Mission Statement

The Spokane Allergy & Asthma Clinic is committed to providing the highest quality individualized care possible, utilizing the most current knowledge and technology, provided by our team of skilled professionals.

Late Policy

We request that you arrive in the clinic **at least 15 minutes** prior to your scheduled time to fill out or clarify insurance papers and referrals. This will allow our nursing staff to get you comfortably into an examination room by the time of your scheduled appointment.

If you arrive significantly later than your scheduled appointment (i.e. **15 minutes or more**) you will be considered a "work-in" patient and will be seen as the provider's schedule allows. If there is no time available for the duration of your provider's scheduled session, the clinical team will work with you to provide the best alternative, or to reschedule for another day.

No Show/Cancel Policy

IMPORTANT- PLEASE READ CAREFULLY

If you fail to show up for your scheduled visit or call later than 8:00 am the day of your visit to cancel, there will be a no-show or late cancellation fee of \$50.00.

WELCOME TO THE SPOKANE ALLERGY & ASTHMA CLINIC

BOARD CERTIFIED ALLERGY & ASTHMA
SPECIALISTS

Your Appointment is With:

- Michael Kraemer, MD
- Steven Kernerman, DO
- Kerry Drain, MD
- Ronald England, MD
- Cinda Reed, ARNP

Appointment Time: _____

Location: _____

- Spokane:** 508 West 6th Ave, Suite 700
Spokane, WA 99204
Phone: 509-747-1624
Fax: 509-747-6774
Hours: Monday-Friday 8am-5pm
- Colfax** 3 Forks Orthopedic Clinic
1200 W Fairview
Three Forks Building
- Pullman** 825 SE Bishop Blvd. Suite 140

Please call the Spokane Clinic at 509-747-1624 to schedule a visit for all clinics.

Eastern Washington: 1-800-400-1624

Email: saac@spokaneallergy.com

Website: spokaneallergy.com

SPOKANE ALLERGY and ASTHMA CLINIC
508 W 6TH STE 700 SPOKANE WA 99204 509-747-1624

Dear Patient and/or Parent/Guardian:

This form and your signature below serves as formal notification of our patient balance/billing policy.

We will bill your insurance company as a courtesy. If for **any reason** there is no response from your insurance company, you will get a bill from us and you will need to pursue this matter with your insurance company, and payment is expected to be paid to our office. The balances are usually for any unpaid medical services to you by our office, co-payments, co-insurance, information needed from the insured or member, non-met deductibles, non-covered services per your particular plan's benefits, pre-existing condition not payable by your insurance particular plan, or **no show/late cancellation fees**.

It is the policy of our office to send only three statements. The statements are sent at 25-day intervals. We will send you collection letters as well. If no payment is received on your account during the 75-day period, your account will be turned over to collections without additional notice. We feel that two months is a reasonable amount of time to make payments on your account.

For your convenience, accounts can be paid using your MasterCard or Visa. You can indicate your credit card information on the statement. You may also pay it over the phone using the credit cards listed.

FINANCIAL SERVICES:

We understand that there may be times when financial difficulties arise without warning. Under special circumstances, payment arrangements may be made. Accounts on a payment plan are required to make a payment each month. Missed payments could result in collections. Please contact our Billing Department at 509-747-1624 for any questions or to set up payment arrangements.

Your signature on this form acknowledges your understanding of this policy. Thank you for choosing Spokane Allergy and Asthma clinic for your medical care.

Date: _____

Patient Name (please PRINT)

If patient is a minor, parent/guardian NAME

Patient or Parent/Guardian SIGNATURE

(over)

SPOKANE ALLERGY and ASTHMA CLINIC

Who may be contacted in the event of an emergency?

Name: _____ Phone: _____ Relationship: _____

May we leave personal information on your answering machine at home? ___ work? ___ cell? ___?

If yes, names of people we can give info to: _____

ASSIGNMENTS OF INSURANCE BENEFITS:

I assign all medical, surgical, immunology benefits to which I am entitled; private insurance and any other health plans to: **SPOKANE ALLERGY AND ASTHMA CLINIC**. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that responsibility for payment of Medical Services in this office for myself or my dependants is mine, due and payable at the time services are rendered. I further understand that insurance is billed as a courtesy and I am responsible for any charges unpaid by the carrier.

I understand there is a *minimum* charge of \$50.00 for **missed** appointments or appointments **not cancelled with at least 24 hours'** notice. **We Require 24-hour Notice to Cancel Appointments.**

Signature: _____ **Date:** _____

****** Financial Policy for MEDICARE PATIENTS ******

Please check one: I have paid my insurance deductible for the calendar year:

_____ Yes _____ No _____ Don't Know

MEDICARE PATIENTS ONLY:

I request payment of authorized Medicare benefits be made either to me or on my behalf to **Spokane Allergy and Asthma Clinic** for any services furnished to me by the listed provider/supplier.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

MEDICARE Patient's Name (Please Print): _____

MEDICARE Patient's Signature: _____

MEDICARE NO. _____ DATE: _____

PROVIDER: _____

SPOKANE ALLERGY and ASTHMA CLINIC

Please **PRINT** clearly:

Today's date: ___/___/___

Patient Information: ___ New patient ___ Name change ___ Address change ___ Insurance change

Patient: _____

SSN#: _____/_____/_____ Date of Birth: _____/_____/_____ Age: _____ Sex: ___ male ___ female

Home Address: _____ City _____ State ___ Zip _____

Mailing Address: if different: _____

Phone: Which number do you prefer we call first? ___ Home ___ work ___ cell ___ message

Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____ Mess: (____) _____ - _____

E-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Date of Birth: _____/_____/_____

First Middle Last

Address: _____ City _____ State ___ Zip _____

Home Phone: (____) _____ - _____ Work phone: (____) _____ - _____ Cell: (____) _____ - _____

Relationship to Patient: _____

PAYMENT POLICY

The Adult or Guardian, who brings in the patient if a child, will be responsible for **all** copayments and deductibles. Spokane Allergy and Asthma Clinic will **not** forward bills to other parties, regardless of court rulings or divorce decrees.

PRIMARY INSURANCE COVERAGE:

Insurance Company Name: _____ Policy Type: ___ HMO ___ PPO

Address of Claim Center: _____ City _____ State ___ Zip _____

Member ID #: _____ Group Name or ID#: _____

The following is **REQUIRED if the insured is not the subscriber of the insurance.

Name of Subscriber: _____ Subscriber's ID #: _____

Subscriber's SSN#: _____/_____/_____ Subscriber's Date of Birth: _____/_____/_____

Relationship to insured: ___ Self ___ Mother ___ Father ___ Spouse ___ other

SECONDARY INSURANCE COVERAGE:

Insurance Company Name: _____ Policy Type: ___ HMO ___ PPO

Address of Claim Center: _____ City _____ State ___ Zip _____

Member ID #: _____ Group Name of ID#: _____

** The following is **REQUIRED** if the insured is not the subscriber of the insurance.

Name of Subscriber: _____ Subscriber's ID#: _____

Subscriber's SSN#: _____/_____/_____ Subscriber's Date of Birth: _____/_____/_____

Relationship to insured: ___ Self ___ Mother ___ Father ___ Spouse ___ other

Signature: _____ Date: _____

**SPOKANE ALLERGY AND ASTHMA CLINIC
ALLERGY QUESTIONNAIRE**

Please complete this questionnaire to have it available before your first office visit. This information is part of your medical record and will be treated confidentially. If some questions are not appropriate to your situation, move to the next section.

Patient's Name: _____ Birthday: _____ Consult requested by: _____

Name of Person Filling Out This Form: _____ Date of Visit: _____

What is your primary purpose for this allergy evaluation? _____

RESPIRATORY PROBLEMS

Please check YES for any current SYMPTOMS, or EXPOSURES THAT MAKE THESE SYMPTOMS WORSE. Leave these boxes blank if you do not feel that they have been a recurrent problem.

<p>YES SYMPTOMS</p> <p>EYES</p> <p><input type="checkbox"/> itchy eyes</p> <p><input type="checkbox"/> reddened eyes</p> <p><input type="checkbox"/> excessive tearing</p> <p><input type="checkbox"/> swollen, puffy eyes</p> <p><input type="checkbox"/> allergic "shiners"</p> <p>NOSE, EARS, SINUS</p> <p><input type="checkbox"/> stuffy, congested nose</p> <p><input type="checkbox"/> mouth breathing</p> <p><input type="checkbox"/> nighttime snoring</p> <p><input type="checkbox"/> nasal dripping, and sniffing</p> <p><input type="checkbox"/> nasal itching and sneezing</p> <p><input type="checkbox"/> post nasal drip</p> <p><input type="checkbox"/> increased frequency of "colds"</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> reduced ability to smell</p> <p><input type="checkbox"/> nasal polyps</p> <p><input type="checkbox"/> sinus pressure, headaches, drainage</p> <p><input type="checkbox"/> recurrent sinus infections</p> <p><input type="checkbox"/> ear "popping" or pressure</p> <p><input type="checkbox"/> recurrent ear infections-otitis media</p> <p><input type="checkbox"/> middle ear fluid – (effusions)</p> <p><input type="checkbox"/> diminished hearing</p> <p>MOUTH, THROAT</p> <p><input type="checkbox"/> itchy mouth and throat</p> <p><input type="checkbox"/> hoarse voice</p>	<p>YES SYMPTOMS</p> <p>LUNGS</p> <p><input type="checkbox"/> frequent daytime cough</p> <p><input type="checkbox"/> nighttime coughing</p> <p><input type="checkbox"/> wheezing</p> <p><input type="checkbox"/> chest tightness</p> <p><input type="checkbox"/> chest pain</p> <p><input type="checkbox"/> shortness of breath</p> <p><input type="checkbox"/> exercise intolerance</p> <p><input type="checkbox"/> recurrent bronchitis</p> <p><input type="checkbox"/> recurrent pneumonia</p> <p><input type="checkbox"/> Other: _____</p> <p>YES EXPOSURES THAT MAKE THESE SYMPTOMS WORSE</p> <p><input type="checkbox"/> the spring months (March-June)</p> <p><input type="checkbox"/> the summer months (June-August)</p> <p><input type="checkbox"/> the autumn months (Sept-Nov)</p> <p><input type="checkbox"/> the winter months (Dec-Feb)</p> <p><input type="checkbox"/> very cold air</p> <p><input type="checkbox"/> very hot and humid air</p> <p><input type="checkbox"/> windy days, dust storms</p> <p><input type="checkbox"/> rainy days, wet weather</p> <p><input type="checkbox"/> acquired viral URI's or "colds"</p> <p><input type="checkbox"/> heartburn or acid reflux</p> <p><input type="checkbox"/> exercise or running</p> <p><input type="checkbox"/> crying or yelling</p>	<p>YES EXPOSURES THAT MAKE THESE SYMPTOMS WORSE</p> <p><input type="checkbox"/> prolonged laughter</p> <p><input type="checkbox"/> house dusting</p> <p><input type="checkbox"/> "wet" or moldy areas</p> <p><input type="checkbox"/> barns and hay</p> <p><input type="checkbox"/> springtime pollen</p> <p><input type="checkbox"/> lawn mowing</p> <p><input type="checkbox"/> cleaning solvents</p> <p><input type="checkbox"/> irritating odors</p> <p><input type="checkbox"/> wood smoke</p> <p><input type="checkbox"/> tobacco smoke</p> <p><input type="checkbox"/> scented candles, incense</p> <p><input type="checkbox"/> perfumes, air fresheners</p> <p><input type="checkbox"/> Christmas trees</p> <p><input type="checkbox"/> latex rubber products</p> <p><input type="checkbox"/> cats</p> <p><input type="checkbox"/> dogs</p> <p><input type="checkbox"/> horses</p> <p><input type="checkbox"/> cattle</p> <p><input type="checkbox"/> goats</p> <p><input type="checkbox"/> gerbils</p> <p><input type="checkbox"/> guinea pigs</p> <p><input type="checkbox"/> hamsters</p> <p><input type="checkbox"/> pet mice or rats</p> <p><input type="checkbox"/> rabbits</p> <p><input type="checkbox"/> pet birds or feathers</p> <p><input type="checkbox"/> Other: _____</p>
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At what age did you first begin having these SYMPTOMS? _____

Have you ever had any Allergy Skin testing or blood testing for these problems? _____

Have you ever been treated with Allergy shots? _____

Names of any previous Allergy, ENT, or Respiratory specialists that you have seen: _____

Name and address and phone number of your Primary physician: _____

SKIN, GASTROINTESTINAL AND FOOD-RELATED PROBLEMS

Please check YES for any SYMPTOMS or EXPOSURES OR FOODS THAT MAKE THESE SYMPTOMS WORSE. Leave these boxes blank if you do not feel that they have been a recurrent problem.

YES	SYMPTOMS	YES	EXPOSURES THAT MAKE THESE SYMPTOMS WORSE	YES	FOODS THAT MAKE THESE SYMPTOMS WORSE
	SKIN	<input type="checkbox"/>	cold weather, or contact with ice	<input type="checkbox"/>	barley
<input type="checkbox"/>	dry skin	<input type="checkbox"/>	low humidity, or dry weather	<input type="checkbox"/>	corn or corn by-products
<input type="checkbox"/>	itchy skin	<input type="checkbox"/>	contact with water, or bathing	<input type="checkbox"/>	rice
<input type="checkbox"/>	red and inflamed skin	<input type="checkbox"/>	overheating	<input type="checkbox"/>	peanuts
<input type="checkbox"/>	Eczema	<input type="checkbox"/>	exercise, or sweating	<input type="checkbox"/>	soybeans
<input type="checkbox"/>	red raised itchy "hives"	<input type="checkbox"/>	scratching	<input type="checkbox"/>	green beans, navy beans,
<input type="checkbox"/>	deep tissue swellings	<input type="checkbox"/>	tight clothing, sustained pressure	<input type="checkbox"/>	peas, lentils
<input type="checkbox"/>	recurrent blisters	<input type="checkbox"/>	sustained vibration	<input type="checkbox"/>	walnuts, pecans
<input type="checkbox"/>	contact allergic dermatitis	<input type="checkbox"/>	sunlight	<input type="checkbox"/>	almonds, hazelnuts
<input type="checkbox"/>	recurrent skin infections	<input type="checkbox"/>		<input type="checkbox"/>	cashews, pistachios
	GASTROINTESTINAL	<input type="checkbox"/>	cosmetics	<input type="checkbox"/>	Brazil nuts
<input type="checkbox"/>	recurrent nausea	<input type="checkbox"/>	latex rubber (gloves)	<input type="checkbox"/>	pine nuts
<input type="checkbox"/>	recurrent vomiting	<input type="checkbox"/>	poison ivy/poison oak	<input type="checkbox"/>	mustard
<input type="checkbox"/>	recurrent heartburn	<input type="checkbox"/>	contact with nickel in clothing	<input type="checkbox"/>	sesame or poppy seeds
<input type="checkbox"/>	regurgitation or reflux of food	<input type="checkbox"/>	metals in jewelry	<input type="checkbox"/>	flaxseed
<input type="checkbox"/>	chest pains with swallowing	<input type="checkbox"/>	soaps, detergents,	<input type="checkbox"/>	sunflower seeds
<input type="checkbox"/>	"sticking" of swallowed food	<input type="checkbox"/>	perfumes	<input type="checkbox"/>	buckwheat
<input type="checkbox"/>	recurrent abdominal pains	<input type="checkbox"/>	creams or lotions	<input type="checkbox"/>	cod, salmon, halibut
<input type="checkbox"/>	recurrent diarrhea	<input type="checkbox"/>	topical antibiotics (neomycin)	<input type="checkbox"/>	shrimp, crab, lobster
<input type="checkbox"/>	recurrent constipation	<input type="checkbox"/>	topical eye drops	<input type="checkbox"/>	clams, oysters,
	SYMPTOMS RELATED TO EATING SPECIFIC FOODS	<input type="checkbox"/>	artificial food dyes	<input type="checkbox"/>	beef, lamb, pork,
<input type="checkbox"/>	mouth and throat itching	<input type="checkbox"/>	wine, beer, or alcoholic beverages	<input type="checkbox"/>	chicken, turkey
<input type="checkbox"/>	"hives" or rash only near the mouth	<input type="checkbox"/>	sulfites in foods	<input type="checkbox"/>	apple, peach, cherry
<input type="checkbox"/>	abdominal cramping, pain, nausea	<input type="checkbox"/>	monosodium glutamate (MSG)	<input type="checkbox"/>	berries
<input type="checkbox"/>	widespread "hives" or rash	<input type="checkbox"/>		<input type="checkbox"/>	bananas
<input type="checkbox"/>	worsening eczema	<input type="checkbox"/>	cow's milk, ice cream, cheese	<input type="checkbox"/>	avocados
<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	goat's milk	<input type="checkbox"/>	citrus fruits
<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	eggs	<input type="checkbox"/>	kiwi, mangoes, tropical fruits,
		<input type="checkbox"/>	wheat	<input type="checkbox"/>	carrots
		<input type="checkbox"/>	oats	<input type="checkbox"/>	celery
		<input type="checkbox"/>	rye	<input type="checkbox"/>	potatoes
				<input type="checkbox"/>	Other: _____

At what age did you first begin having these SYMPTOMS? _____

Have you ever had Allergy "Patch testing" done to confirm these sensitivities? _____

Names of any previous Dermatology or Gastroenterology (GI) specialists that you have seen: _____

STINGING INSECT REACTIONS (involving mosquitoes, bees, wasps, hornets, yellow jackets, fire ants, etc.)

Please check YES for any SUSPECTED INSECTS, SYMPTOMS, and REQUIRED TREATMENTS that have occurred with past stinging insect reactions. Leave these boxes blank if there has not been a prior reaction to insect stings.

YES	SUSPECTED INSECTS CAUSING THESE SYMPTOMS	YES	SYMPTOMS OCCURRING AFTER YOUR STING	YES	TREATMENTS REQUIRED FOR THESE SYMPTOMS
<input type="checkbox"/>	I do not know the type of insect..	<input type="checkbox"/>	large localized swelling <u>at the site</u>	<input type="checkbox"/>	urgent care or clinic sick visit
<input type="checkbox"/>	honey bee	<input type="checkbox"/>	widespread rash (hives)	<input type="checkbox"/>	emergency room visit
<input type="checkbox"/>	bumble bee	<input type="checkbox"/>	widespread skin swellings	<input type="checkbox"/>	hospitalization
<input type="checkbox"/>	Wasp	<input type="checkbox"/>	throat tightness, hoarseness	<input type="checkbox"/>	adrenaline injection
<input type="checkbox"/>	hornet (yellow)	<input type="checkbox"/>	cough, chest tightness, wheeze	<input type="checkbox"/>	intravenous fluids
<input type="checkbox"/>	hornet (bald faced)	<input type="checkbox"/>	abdominal pains	<input type="checkbox"/>	oral or injected antihistamines
<input type="checkbox"/>	yellow jacket	<input type="checkbox"/>	nausea, vomiting, diarrhea	<input type="checkbox"/>	oral or injected steroids
<input type="checkbox"/>	fire ant	<input type="checkbox"/>	lightheadedness, altered vision	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Mosquito	<input type="checkbox"/>	lowered blood pressure, shock	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	Other: _____

At what age did you first begin having these sting reactions? _____

Have you ever had Allergy Skin testing or blood testing for this problem? _____

Have you ever been treated with Allergy shots for this problem? _____

Names of any previous Allergy specialists that you have seen for this problem: _____

PREVIOUS MEDICATION REACTIONS

List any medications that have caused an adverse reaction. Describe the type of reaction (i.e. rash, or abdominal pain). Also note your approximate age when this reaction occurred. Leave the boxes blank if you have not had a prior medication reaction.

Medication Name:	Type of reaction:	Approximate age:

ALLERGIC FAMILY HISTORY

Please check the box if other immediate family members have had a history of these problems

	Mother	Father	Brother 1	Brother 2	Sister 1	Sister 2	Other Relatives
Fill in this Person's Name?							
Chronic Atopic Dermatitis or Eczema							
Food Allergies							
Allergic Nasal or Eye Symptoms							
Allergic or Nonallergic Asthma							
Recurrent Hives or Deep Swellings							
Recurrent Middle Ear or Sinus Problems							
Recurrent Migraine Headaches							
Insect Sting Allergies							
Other Health Issues:							

ENVIRONMENTAL EXPOSURES:

Where were you born? _____ Where have you lived in your life? _____
 _____ Where is your current home located? _____
 How old is your current home? _____ years. How many people currently occupy this home? _____

Please check YES for the answers that best describe the basic structure, heating, cooling and filtering systems for this home. Leave the boxes blank if they do not relate to your current home.

<p>YES WHAT IS THE STRUCTURE OF YOUR CURRENT HOME?</p> <p><input type="checkbox"/> single family home</p> <p><input type="checkbox"/> condominium</p> <p><input type="checkbox"/> duplex</p> <p><input type="checkbox"/> apartment</p> <p><input type="checkbox"/> dormitory room</p> <p><input type="checkbox"/> manufactured home</p> <p><input type="checkbox"/> trailer</p> <p><input type="checkbox"/> lake cabin</p> <p><input type="checkbox"/> Other type of structure: _____</p>	<p>YES HOW DO YOU CURRENTLY HEAT THE HOME?</p> <p><input type="checkbox"/> electric baseboard heat</p> <p><input type="checkbox"/> electric wall heaters</p> <p><input type="checkbox"/> steam radiators</p> <p><input type="checkbox"/> hot water radiators</p> <p><input type="checkbox"/> fireplace insert or woodstove</p> <p><input type="checkbox"/> pellet stove</p> <p><input type="checkbox"/> propane stove</p> <p><input type="checkbox"/> gas forced air heat</p> <p><input type="checkbox"/> electric forced air heat</p> <p><input type="checkbox"/> heat pump</p> <p><input type="checkbox"/> other heating sources: _____</p>	<p>YES HOW DO YOU COOL AND/OR FILTER YOUR HOME?</p> <p><input type="checkbox"/> central air conditioner</p> <p><input type="checkbox"/> window-insert air conditioner</p> <p><input type="checkbox"/> we cool the home by opening the windows</p> <p><input type="checkbox"/> central humidifier</p> <p><input type="checkbox"/> room-size humidifier</p> <p><input type="checkbox"/> central air filter</p> <p><input type="checkbox"/> room-size air filter</p> <p><input type="checkbox"/> Other cooling or filtering devices _____</p>
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Please check if you have ever smoked cigarettes? Leave this section blank if you have never smoked cigarettes.

If so, how many years did you smoke? _____ years. If you no longer smoke, what year did you quit? _____
 If you still smoke, how many cigarettes do you smoke per day (on average)? _____ cigarettes/day
 How many smokers currently live in this home? _____

Please check YES for the most common air quality problems in the home. Also check YES for the animals that currently reside inside or outside your home. Leave the boxes blank if they do not apply to your current home.

<p>YES WHAT ARE SOME POTENTIAL AIR QUALITY PROBLEMS?</p> <p><input type="checkbox"/> indoor cigarette smoke</p> <p><input type="checkbox"/> wood smoke</p> <p><input type="checkbox"/> scented candles</p> <p><input type="checkbox"/> incense odors</p> <p><input type="checkbox"/> irritating or noxious smells</p> <p><input type="checkbox"/> excessive dampness</p> <p><input type="checkbox"/> water damaged areas</p> <p><input type="checkbox"/> moldy or musty odors</p> <p><input type="checkbox"/> visible mold in some areas</p> <p><input type="checkbox"/> pet odors</p> <p><input type="checkbox"/> Other air quality concern: _____</p>	<p>YES INSIDE PETS/ANIMALS</p> <p><input type="checkbox"/> cats (number: ____)</p> <p><input type="checkbox"/> dogs (number: ____)</p> <p><input type="checkbox"/> gerbils (number: ____)</p> <p><input type="checkbox"/> Guinea pigs (number: ____)</p> <p><input type="checkbox"/> hamsters (number: ____)</p> <p><input type="checkbox"/> pet rats (number: ____)</p> <p><input type="checkbox"/> pet mice (number: ____)</p> <p><input type="checkbox"/> rabbits (number: ____)</p> <p><input type="checkbox"/> birds (number: ____)</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Other: _____</p>	<p>YES OUTSIDE PETS/ANIMALS</p> <p><input type="checkbox"/> cats (number: ____)</p> <p><input type="checkbox"/> dogs (number: ____)</p> <p><input type="checkbox"/> horses (number: ____)</p> <p><input type="checkbox"/> cattle (number: ____)</p> <p><input type="checkbox"/> sheep (number: ____)</p> <p><input type="checkbox"/> goats (number: ____)</p> <p><input type="checkbox"/> rabbits (number: ____)</p> <p><input type="checkbox"/> birds (number: ____)</p> <p><input type="checkbox"/> llamas, alpacas (number: ____)</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Other: _____</p>
---	---	---

Current Work Exposures: (if applicable)

Where are you currently employed? _____

Describe your job: _____

Are there any workplace exposures that cause symptoms? _____

Current School Exposures: (if applicable)

What is the name of your school? _____ Grade: _____

Are there any school exposures that cause symptoms? _____

Current Daycare or Preschool Exposures: (if applicable)

What is the name of your daycare or preschool? _____

How many days/week do they usually attend this facility? _____ How many hours/day do they attend? _____

How many other children are at this facility (estimate)? _____

Are there any exposures here that cause symptoms? _____

List your **Current Prescription and Nonprescription Medication Names**, including all topical ointments, creams, herbal remedies, and oral supplements. Write down the **Usual Dosage and Frequency**. For the **Source of this Medication**, include the name of the person providing this prescription, or write "OTC" if it is available "Over-The-Counter", or without prescription.

Current Medication Names:	Usual Dosage and Frequency:	Source of this Medication:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

ADDITIONAL MEDICAL AND SURGICAL INFORMATION

Please check YES for any ACTIVE PROBLEM that has not yet been listed. Leave the boxes blank if you do not feel that they are an active concern.

<p>YES ACTIVE PROBLEMS</p> <p><input type="checkbox"/> learning difficulties in school</p> <p><input type="checkbox"/> school or work absenteeism</p> <p><input type="checkbox"/> ADD/ADHD, hyperactivity</p> <p><input type="checkbox"/> chronic depression</p> <p><input type="checkbox"/> chronic anxiety, panic disorder</p> <p><input type="checkbox"/> history of alcohol abuse</p> <p><input type="checkbox"/> history of drug abuse</p> <p><input type="checkbox"/> Other emotional or psychiatric problem: _____</p> <p><input type="checkbox"/> Do you have a diagnosed immune deficiency? _____</p> <p><input type="checkbox"/> chronic fatigue</p> <p><input type="checkbox"/> recurrent fevers</p> <p><input type="checkbox"/> recurrent night sweating</p> <p><input type="checkbox"/> swollen lymph nodes (glands)</p> <p><input type="checkbox"/> excessive weight gain</p> <p><input type="checkbox"/> poor appetite</p> <p><input type="checkbox"/> failure to gain weight</p> <p><input type="checkbox"/> short stature</p> <p><input type="checkbox"/> dental cavities, tooth decay</p> <p><input type="checkbox"/> orthodontic problems</p> <p><input type="checkbox"/> periodontal gum disease</p> <p><input type="checkbox"/> anemia</p> <p><input type="checkbox"/> other blood disorder: _____</p>	<p>YES ACTIVE PROBLEMS</p> <p><input type="checkbox"/> psoriasis</p> <p><input type="checkbox"/> acne</p> <p><input type="checkbox"/> rosacea</p> <p><input type="checkbox"/> other skin disorder: _____</p> <p><input type="checkbox"/> vision that requires correction (glasses, contacts, Lasik)</p> <p><input type="checkbox"/> cataracts</p> <p><input type="checkbox"/> glaucoma</p> <p><input type="checkbox"/> other eye disease: _____</p> <p><input type="checkbox"/> recurrent strep throat</p> <p><input type="checkbox"/> vocal cord dysfunction</p> <p><input type="checkbox"/> other throat disorder: _____</p> <p><input type="checkbox"/> high cholesterol levels</p> <p><input type="checkbox"/> high blood pressure</p> <p><input type="checkbox"/> heart murmur</p> <p><input type="checkbox"/> abnormal heart rhythm</p> <p><input type="checkbox"/> coronary artery disease</p> <p><input type="checkbox"/> other heart abnormality: _____</p> <p><input type="checkbox"/> irritable bowel syndrome</p> <p><input type="checkbox"/> inflammatory bowel disease</p> <p><input type="checkbox"/> other gastrointestinal disease: _____</p> <p><input type="checkbox"/> hypothyroidism or hyperthyroidism</p> <p><input type="checkbox"/> diabetes, or "pre-diabetes"</p> <p><input type="checkbox"/> other endocrine disease: _____</p>	<p>YES ACTIVE PROBLEMS</p> <p><input type="checkbox"/> recurrent joint pains</p> <p><input type="checkbox"/> recurrent back pains</p> <p><input type="checkbox"/> fibromyalgia</p> <p><input type="checkbox"/> rheumatoid arthritis</p> <p><input type="checkbox"/> osteoarthritis</p> <p><input type="checkbox"/> systemic lupus erythematosus</p> <p><input type="checkbox"/> osteoporosis, or osteopenia</p> <p><input type="checkbox"/> other bone or joint disease: _____</p> <p><input type="checkbox"/> enlarged prostate</p> <p><input type="checkbox"/> frequent or difficult urination</p> <p><input type="checkbox"/> recurrent urinary tract infections</p> <p><input type="checkbox"/> other kidney or bladder disease: _____</p> <p><input type="checkbox"/> Are you currently pregnant? _____</p> <p><input type="checkbox"/> menstrual irregularities</p> <p><input type="checkbox"/> post menopausal symptoms</p> <p><input type="checkbox"/> other obstetric/gynecologic probs: _____</p> <p><input type="checkbox"/> recurrent migraines</p> <p><input type="checkbox"/> recurrent seizures</p> <p><input type="checkbox"/> recurrent shaking, or tremors</p> <p><input type="checkbox"/> restless legs syndrome</p> <p><input type="checkbox"/> other neurological disorder: _____</p> <p><input type="checkbox"/> problems with insomnia</p> <p><input type="checkbox"/> sleep apnea</p> <p><input type="checkbox"/> other sleep disorder: _____</p>
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Who is your PRIMARY CARE provider? _____

List any other MEDICAL OR DENTAL SPECIALTY CONSULTANTS that you have seen: _____

List any past HOSPITALIZATIONS that you have not yet mentioned (include the year): _____

List any past SURGERIES that have been performed (include the year): _____

List any significant PAST MEDICAL PROBLEMS. These are problems that are now RESOLVED, and require no further treatments or monitoring. List any past CANCER history here. _____

Is there any other question or concern that you would like to discuss with your Provider during this initial evaluation? _____

Spokane Allergy & Asthma Clinic
508 W 6th Ave, Ste 700
Spokane Wa 99204
509 - 747-1624

COMING FROM THE NORTH:

Take Division into downtown. After you cross the river, get in the far right lane. Follow this to Spokane Falls Boulevard. Now get in far left lane. At Stevens Street, turn left. Straight on Stevens through the next six lights, up the hill to 6th Avenue. Our parking lot is on the SE corner of 6th and Stevens (on the left corner). Our office building is on the NW corner of 6th and Stevens (on the right corner).

COMING FROM THE SOUTH:

Take Grand Boulevard, left lane. At Sacred Heart Hospital on 8th Avenue, turn Left at the light (8th & McClellan) -- which then curves into Washington St, heading northward. Stay left lane, ready to turn left at next light – on 6th Avenue. Our parking lot is on 6th, between Washington and Stevens. Our office building is on the NW corner of 6th and Stevens.

COMING FROM THE EAST:

From I-90, take exit 281 at Division Street – get in left lane. You will be at 3rd Avenue. Go straight 1 block to 2nd Avenue, turn left. On 2nd, stay in the left lane and go 5 blocks. Turn left on Stevens. On Stevens, stay in left lane and go 4 blocks to 6th Ave. Turn left on 6th. When you turn left, our parking lot is now on your right, at the SE corner. Our office is on the NW corner of 6th & Stevens.

COMING FROM THE WEST:

From I-90, take exit 281 at Division Street – get in left lane. Turn left at the light at the end of the off-ramp. Stay in the left lane. Go straight to 2nd Avenue, turn left. On 2nd, stay in the left lane for 5 blocks, turn left on Stevens. On Stevens, stay in left lane and go 4 blocks to 6th Avenue. Turn left on 6th. When you turn left, our parking lot is now on your right, at the SE corner. Our office is on the NW corner of 6th & Stevens.

Our office is on the 7th floor, Suite 700 in the beige Qual-Med/Molina Building. No charge for parking. Handicapped parking available in front of our building – limited spaces.